TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MISI ASC Dallas LLC

Respondent Name
Texas Mutual

MFDR Tracking Number
M4-16-2950-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed the claim to Texas Mutual in a timely manner and they denied the claim for past timely filing so we printed our screen shot to support the date the claim was billed to them in an appeal that was sent to them on 4/20/16 via fax and that too has been denied original decision upheld."

Amount in Dispute: $1,278.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual first received the bill for date 10/16/15 from MISI ASC Dallas on 2/4/16, a date greater than 95 days form 10/16/15."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2015	64493-RT, 64493-LT, 59, 64494 - RT, 69994-LT, 59	$1,278.85	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – "The time limit for filing has expired." 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." The requestor submitted a screen shot showing a billed date of "11/2/2015" however, no claim form with this submitted date was found nor was any supporting documents to support timely electronic submission or faxed transmission. Therefore, the carrier's denial is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.